



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Region IX
Division of Medicaid & Children's Health Operations
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

JUL 10 2009

Mr. Toby Douglas
Chief Deputy Director of Health Care Programs
California Department of Health Care Services
1501 Capital Avenue, MS 0000
P. O. Box 997413
Sacramento, California 99859-7413

Dear Mr. Douglas:

Enclosed is the final Financial Management Review report (Control Number 09-FS-2007-CA-01-F) examining "California's Adult Day Health Care Program".

The purpose of the review was to document the types of services provided by Adult Day Health Care (ADHC) Centers that are included in the current bundled rate, and document if the services provided by ADHC Centers are or are not allowable per current federal regulations and/or the California State Plan. In addition, the review documented the rate methodology and service provisions of SB 1755, and compared the rate methodology and service provisions of SB 1755 to the methodology and services allowable by the Social Security Act, the California State Plan, the Deficit Reduction Act of 2005 and other relevant laws and regulations.

We appreciate your November 14, 2008, response to the draft report in which you requested technical assistance from CMS as you move forward with implementing the changes required in SB1755. In addition, in your response you reiterated the State's opinion that adding personal care services provided by Adult Day Health Care Centers to the State's personal care services benefit in California's Medicaid State Plan would be inappropriate. Unfortunately, since ADHC services are not recognized as a specific coverable service under 1905(a) of the Social Security Act, the State must amend its State plan in order to continue to provide these services as reimbursable Medi-Cal services at Adult Day Health Care Centers.

We have incorporated your response into the enclosed final report, and look forward to assisting California in designing an approvable methodology for the provision of personal care and other ancillary health care services within Adult Care Health Center settings.

Should you or your staff have any questions regarding this matter, please contact Ronna Bach at (415) 744-3576 or e-mail ronna.bach@cms.hhs.gov.

Sincerely,

A handwritten signature in black ink, appearing to read "Gloria Nagle". The signature is fluid and cursive, with the first name "Gloria" and last name "Nagle" clearly distinguishable.

Gloria Nagle, Ph.D., MPA
Associate Regional Administrator
Division of Medicaid and Children's Health Operations



Financial Management Review

CALIFORNIA'S ADULT DAY HEALTH CARE PROGRAM

#09-FS-2007-CA-01-F

**STATE OF CALIFORNIA
DEPARTMENT OF HEALTH SERVICES
SACRAMENTO, CALIFORNIA**

FOR THE PERIOD MARCH 1, 2007 - MAY 31, 2007

February 2009

**DIVISION OF MEDICAID AND CHILDREN'S HEALTH OPERATIONS
CENTERS FOR MEDICARE & MEDICAID SERVICES
SAN FRANCISCO REGIONAL OFFICE**

Executive Summary

The purpose of this Financial Management Review (FMR) is to document (1) the types of services provided by Adult Day Health Care (ADHC) Centers that are included in the current bundled rate, (2) document if the services provided by ADHC Centers are or are not allowable per current Federal regulations and/or the State plan, (3) document the rate methodology and service provisions of California Senate Bill (SB) 1755, and (4) compare the rate methodology and service provisions of SB 1755 to the methodology and services allowable by the Social Security Act, the State plan, the Deficit Reduction Act of 2005 (DRA) and other relevant laws and regulations.

The CMS review team conducted interviews with State personnel, reviewed applicable sections of the Social Security Act, the Federal Code of Regulations, the California Code of Regulations and the DRA, and visited a sample of ADHC providers. The team found the following:

- Adult Day Health Care Centers receive payments for services that are not eligible for reimbursement under the Federal Medicaid program.
- While the State plan authorizes coverage of personal care services, Adult Day Health Care Centers are not eligible providers under the approved State plan.
- Adult Day Health Care providers are paid using a bundled rate methodology that is inconsistent with Section 1902(a)(30)(A) of the Act.

Based upon these findings, CMS recommends the following:

- The California Department of Health Care Services (DHCS) must submit a State plan amendment (SPA) that reflects a reimbursement methodology not dependent upon a bundled rate methodology and that excludes the reimbursement of non-1905(a) services.

CMS recommends that the DHCS review and evaluate if the above recommendation might be best achieved by seeking approval for a Section 1915(i) SPA, which allows the use of bundled rates. Alternatively, the State could submit a Section 1915(c) waiver, which also allows reimbursement of bundled rates. Both alternatives allow the State to include in the payment rates additional costs beyond those allowed as 1905(a) services.

- The DHCS must submit a State plan amendment (SPA) that identifies ADHC Centers as an allowable site where personal care services may be delivered.

Additionally, while California Senate Bill 1755 seeks to tighten many ADHC rules and amend the program's reimbursement methodology, the team found that some of the Bill's proposed corrections may be inconsistent with the requirements of the Federal Medicaid program.

BACKGROUND

Title XIX of the Social Security Act (the Act) authorizes Federal grants to states for Medicaid programs that provide medical assistance to needy individuals. Federal funds are available to states for expenditures associated with the medical care of low-income families, persons with disabilities, and the elderly, if the medical payments have been made pursuant to an approved State plan.

Effective September 1, 1982, Adult Day Health Care (ADHC) was added to the California State Plan. California SPA 82-20 and 82-21 added a wide range of services to Attachments 3.1A and 3.1B of the State plan. The ADHC was added as a service under the hospital outpatient/clinic and rehabilitative services in the California State plan (Attachment 1). The reimbursement methodology for SPAs 82-20 and 82-21 appears on Pages 1 to 3 of Attachment 4.19B in the State plan, in a section entitled "Reimbursement Limits for Professional Services" (Attachment 2). This section of the State plan contains general information regarding the payment methodology for services other than institutional services and refers the reader to specific sections in the California Code of Regulations (CCR) Title 22. Based on Attachment 4.19-B, page 1, professional services are paid based upon the establishment of the payment rates through the State Agency's adoption of regulations in Title 22. ADHC is not mentioned by name in this section and there is no mention of its reimbursement methodology in any other section of the State plan.

SPA 82-20 and SPA 82-21 contained no information about what medical services are provided in ADHC Centers. Rather, this information is found in the California Code of Regulations (CCR), Title 22, Sections 54001 through 54507 and Sections 78001 through 78609. Sections 54309 and Section 78301 in Title 22 of the CCR states that ADHC Centers must provide: (1) rehabilitation services (which include occupational, physical and speech therapy); (2) medical services; (3) nursing services; (4) nutrition services; (5) psychiatric or psychological services (6) social work services; (7) planned recreational and social activities, and (8) transportation services.

Title 22, Section 54423 gives an indication of the amount of mandated services each ADHC Center is required to provide by listing the minimum staffing levels. Minimum staffing positions for ADHC Centers are: a program director, registered nurse, medical social worker, program aide, and activity coordinator. Other staff are employed in sufficient numbers to provide the services needed, but following are the minimal requirements, which are based on average daily attendance up to 60.

| Service | Minimal Staffing Requirement |
|--|--|
| Physical therapy, speech therapy, occupational therapy, psychiatric services, and psychological services | 40 to 240 hours per month depending on ADHC Center size; averages 4 hours per month for each beneficiary |
| Nutritional services | 2 to 10 hours per month per ADHC Center |

Additional half-time licensed vocational nurses and social work assistants are required for each increment of 10 participants for Centers whose average daily attendance exceeds 40. Additional

program aides are to be provided in a ratio of one-half aide for every eight in average daily attendance. In ADHC Centers with less than 20 participants, the program director can also serve as the registered nurse, social worker, occupational therapist, physical therapist, speech therapist or dietician provided that he or she meets the professional requirements for that position.

On July 1, 1988, SPA 88-17 clarified several ADHC service features. The amendment specified how eligibility for ADHC services should be determined, who is eligible for ADHC services, and the accompanying materials that must be submitted with a request for service authorization. No guidance relating to ADHC services was added to the plan, thus the California Medicaid State plan still contains no mention of what services are provided in ADHC Centers.

The ADHC rate structure was changed to a flat daily rate per participant day of attendance in 1986, when the rate was \$37.68 per day for four hours of attendance. Between 1986 and 1994, there were only two rate increases: one in 1987 and one in 1989. The California Association for Adult Day Services (CAADS) sued the California Department of Health Services (now known as the California Department of Health Care Services (DHCS)) in the early 1990s. Pursuant to the settlement of this suit, the ADHC rate was tied to the rate of nursing facilities effective August 1, 1997. Since August 1997, the ADHC bundled payment rate has steadily increased. The settlement between CAADS and DHCS requires that the ADHC rate be increased to 90% of the nursing facility rate each time DHCS increases the nursing facility rate. In Federal fiscal year 2007, the total computable expenditures associated with ADHC services was \$393 million.

Based upon a review of ADHC information in the State's regulations conducted several years ago, CMS identified that the bundled rate paid for ADHC services included non-medical services and brought it to the State's attention. Largely in response to CMS' concerns, the California legislature enacted Senate Bill (SB) 1755 in September 2006. While the enacted legislation does provide further clarification regarding ADHC services and its reimbursement methodology, the legislation does not resolve all of CMS' concerns related to ADHC services and how such services are reimbursed.

PURPOSE, METHODOLOGY AND SCOPE

Purpose

The objectives of this Financial Management Review (FMR) were to: (1) document the types of services provided by ADHC Centers that are included in the bundled rate, (2) document if the services provided by ADHC Centers are or are not allowable per current Federal regulations and/or the State plan, (3) document the rate methodology and service provisions of SB 1755, and (4) compare the rate methodology and service provisions of SB 1755 to the methodology and services allowable by the Act, the State plan, the Deficit Reduction Act of 2005 (DRA) and other relevant laws and regulations.

Methodology

To accomplish the objectives, the review team conducted interviews with State personnel and reviewed applicable sections of the Social Security Act, the Federal Code of Regulations, the California Code of Regulations and the DRA.

In addition, the team conducted field work by visiting six ADHC Centers located throughout the State. Two of the ADHC Centers visited were located in the San Francisco Bay Area, two were located in Sacramento County and two were in Southern California. Three of the six sites visited were selected with the assistance of personnel at DHCS. While at each field site, the team conducted interviews with the Administrators and/or the Program Directors employed by the ADHC Centers, and reviewed a limited number of health service records associated with Medicaid beneficiaries.

Scope

All of the health service records we reviewed were randomly selected prior to the field site visits and reflected service delivery dates from March 1, 2007, through May 31, 2007. Ten health service records were reviewed at each ADHC Center visited. The specific health service records we reviewed included:

- the individualized plan care (IPC),
- attendance records, and
- service delivery records.

Additionally, the review team requested copies of the service flow sheets for each beneficiary health record to compare with attendance records. The team randomly selected a week during the review period and requested flow sheets from the sample population. After one-on-one interviews were conducted, the review team contacted the six ADHC Centers and requested copies of beneficiaries' flow sheets for the week of April 16-20, 2007. Five of the six ADHC Centers sent flow sheets to the CMS Regional Office. Of the 50 flow sheets received, 19 reported the beneficiary had been discharged or died, or was not in attendance during the week under review. Twenty-eight of the 31 (90%) completed records showed that approved ADHC services were provided on days when the beneficiary was in attendance. There were discrepancies with the remaining three (10%) records in that the ADHC services documented on the flow sheets did not correspond to the attendance logs.

| Total Sample | Number of Flow Sheets Received | Effective Sample Size | Number of Completed Flow Sheets with no attendance discrepancies | Number of Completed Flow Sheets with Attendance Discrepancies |
|--------------|--------------------------------|-----------------------|--|---|
| 60 | 50 | 31 | 28 | 3 |

The team noted that of the 31 completed flow sheets in our sample, most were well documented. Many of the flow sheets provided extensive documentation of the services received and clearly indicated the types of activities performed.

The review team also examined if the ADHC services approved in the beneficiary's IPC were provided and documented in the beneficiary's flow sheets. Twenty-two (79%) of the 28 beneficiary flow sheets reviewed indicated that the beneficiary did receive those ADHC services identified in their IPCs during the defined week period. The remaining six (21%) beneficiaries

only received some of the ADHC services that were identified in their IPCs. Reasons for not receiving all approved ADHC services include beneficiary's refusal to receive certain services (3); an approved service was either not provided or not documented on the flow sheet (2); or the facility was unable to provide a copy of the flow sheet (1).

FINDINGS

1. Adult Day Health Care Centers receive payments for services that are not eligible for reimbursement under the Federal Medicaid program.

The Individualized Plan of Care (IPC) is used by ADHC providers to list the types and frequency of services to be received by persons attending ADHC Centers. While performing this review, the team examined the IPCs of 58 Medicaid beneficiaries attending six different ADHC Centers. All of the IPCs reviewed indicated that the Medicaid beneficiaries received "nutrition" as a service. During interviews with the Administrators and/or the Program Directors of the six ADHC Centers visited, the team concluded that ADHC Centers routinely provide one meal to Medicaid beneficiaries attending a Center for the four-hour minimum day.

Meals, however, are not a medical service eligible for payment under Section 1905(a) of the Social Security Act.

In addition to meals, we found that most of the IPCs reviewed indicated that beneficiaries also receive "recreational" services. All of the ADHC Centers we visited categorized recreational activities as table-top games, dancing, and observing audio-visual programs. As with meals, the Federal Medicaid program does not include "recreational" services as a Section 1905(a) service eligible for medical assistance payments.

Meals and recreational services have been offered by ADHC providers since ADHC coverage was added to the State plan in 1982. CMS' efforts to exclude non-State plan services, such as meals and recreational services, however, have been hindered by a bundled rate payment methodology that precludes the ability to limit Federal funding solely to those services eligible for medical assistance.

2. While the State plan authorizes coverage of personal care services, Adult Day Health Care Centers are not eligible providers under the approved State plan.

Almost all of the IPCs reviewed reflect that beneficiaries receive "personal care" services. Personal care services were added to the State Plan, effective October 1994, for the categorically needy (see Attachment 3.1A) and were expanded to the medically needy (see Attachment 3.1B) in April 1999. Personal care services include such activities as assisting with the administration of medications, providing needed assistance or supervision with basic hygiene, eating, grooming, toileting and other incidental activities. The State plan originally limited the performance of these services to a recipient's home. Effective January 1, 2003, SPA 02-021 extended the "place-of-delivery" limitation to a beneficiary's place of employment. However, the State plan does not authorize the performance of these services at ADHC Centers. Accordingly, the ADHC

Centers are receiving Federal financial participation (FFP) for a service that is not authorized by the State plan. In addition, the State plan limits the amount of personal care services to no more than 283 hours per month. During our review, however, we were unable to identify any mechanism used by ADHC Centers that indicated this service limitation was monitored to avoid exceeding it, when added to hours used by beneficiaries in their homes or at their worksite.

As with meals and recreational services, CMS' ability to exclude payment of a non-State plan service is barred by the bundle rate methodology used to reimburse ADHC providers.

3. Adult Day Health Care providers are paid using a bundled rate methodology that is inconsistent with Section 1902(a)(30)(A) of the Act.

Although ADHC has historically been reimbursed using a bundled rate, effective August 1, 1998, the bundled rate paid to ADHC Centers became equivalent to "90% of the statewide weighted average Medi-Cal rate per patient day provided for the 1997-98 fiscal year to Nursing Facilities – Level A." This rate is commonly referred to as the "90% of NF-As" rate and was established pursuant to a legal settlement between the California Association for Adult Day Services (CAADS) and DHCS. The settlement further directed that the ADHC reimbursement rate be increased any time "the statewide weighted average for the NF-A reimbursement rate increases."

Since August 1, 2006, the ADHC bundled rates have been as follows:

- ✓ \$76.22 Regular four-hour service day
- ✓ \$80.03 Initial assessment day with subsequent attendance limited to three assessment days every 12 months.
- ✓ \$80.03 Initial assessment day without subsequent attendance
- ✓ \$64.79 Transition day. Five-day lifetime limit.
Transition days can occur if the physician's authorization expires without renewal.

In December 2003, CMS informed the DHCS that the bundled rate payment methodology used to reimburse ADHC was problematic. Specifically, as discussed earlier in this report and as acknowledged by the State, the bundled rate allows for the reimbursement of both State plan and non-State plan services. Furthermore, the 90% of NF-A rate equates the cost of care provided by ADHC Centers with the cost required to provide care in an intermediate care nursing facility. CMS believes that this cost relationship is inappropriate given the State plan dictates that a primary eligibility requirement for ADHC services is that the services required by beneficiaries "are not of such a serious nature as to require 24-hour nursing care." Finally, CMS believes that the bundled rate methodology the State is using for ADHC Centers is inconsistent with Section 1902(a)(30)(A) of the Act which requires that States have methods and procedures to assure that payments are consistent with efficiency, economy, and quality of care.

The bundled rate payment methodology allows the DHCS to pay a single rate for more than one service furnished to an eligible beneficiary regardless of the number of services furnished or the specific costs of the service. Since the bundled rate is not reflective of the types or numbers of services provided, or even the actual costs of providing services, the rate is inconsistent with the Act's economy provisions. Similarly, since bundled rates require substantially more Federal oversight to establish the accuracy and reasonableness of the rate, CMS does not regard bundled rates as efficient.

RECOMMENDATIONS

1. The DHCS must submit a State plan amendment (SPA) that reflects a reimbursement methodology that is not dependent upon a bundled rate methodology and that excludes the reimbursement of non-1905(a) services.

CMS recommends that the DHCS review and evaluate if the above recommendation might be best achieved by seeking approval for a Section 1915(i) SPA, which allows the use of bundled rates. Alternatively, the State could submit a Section 1915(c) waiver, which also allows reimbursement of bundled rates. Both alternatives may allow the State to include in the payment rates additional costs beyond those allowed as 1905(a) services.

2. The DHCS must submit a State plan amendment (SPA) that identifies ADHC Centers as a specific site where personal care services may be delivered.

NOTE: The State Agency must have an approved SPA that addresses and corrects the issues covered by the two recommendations above by July 1, 2009. Failure to do so will put Federal funding at risk.

OBSERVATIONS RELATING TO SENATE BILL 1755

In September 2006 the California legislature enacted Senate Bill 1755. The bill tightens ADHC rules and alters aspects of the reimbursement methodology used to pay ADHC providers. Important changes to the California Welfare & Institutions Code include:

- Section 14525 which adds specific eligibility requirements,
- Section 14526.1 which adds new medical necessity criteria,
- Section 14550.5 which adds minimum service requirements, and
- Section 14571.2 which directs that some specifically identified services be separately billed and that other services be billed at within a core rate.

The core services, as defined in Section 14550.5 of the California Welfare & Institutions Code, are services which must be provided to each participant in order for the Center to bill Medi-Cal for their per diem rate. The core services are:

- Professional nursing services
- Personal care services and/or social services
- Therapeutic activities
- One meal

Specialized services are services which have been broken out of the previous bundled rate and are to be separately billed. Specialized services are:

- Physical therapy
- Occupational therapy
- Speech and language pathology
- Registered dietician
- Mental health
- Transportation to and from the center

SB 1755 unbundles most of the professional services and tightens many ADHC service and reimbursement requirements, which will help strengthen the program. In spite of these changes, however, the legislation retains features that are inconsistent with Sections 1905(a) and 1902(a)(30)(A) of the Social Security Act. Specifically, Section 14550.5 of the bill identifies the core services that must be offered on a daily basis by ADHC Centers. Subsequent Section 14571.2(c) directs that these core services be billed within a bundled rate. For the reasons identified earlier in this report, bundled rates are inconsistent with Section 1902(a)(30)(A) of the Social Security Act. The core rate still contains a combination of professional services (nursing) and non-professional services, which generally cannot be approved as part of a payment methodology. When the State submits a State Plan to implement this payment methodology, CMS will work with the State to ensure that the Medicaid payments received by ADHC Centers are related to the services provided by the practitioners and the cost of employing those practitioners.

Also, Section 14571.2(e) of SB 1755 states in part that “a reimbursement limit applicable to each adult day health care center peer group established (be) ... based on cost containment principles applied to other acute care and long-term care providers.” However, CMS would like to point out that ADHCs do not satisfy Federal Medicaid requirements that would allow the Centers to be recognized as institutions per Section 1919(a) of the Act (nursing facilities) or Section 1000B of the State Operations Manual (acute care facilities). Accordingly, any peer group reimbursement limit established for ADHC Centers cannot be based on cost containment principles associated with acute care and long-term care providers.

STATE'S RESPONSE

In their response to the draft report, dated November 14, 2008, (included in this report on pages 11-15), the State of California did not agree to the timeframe required by CMS for implementing changes to its state plan addressing the delivery of services by Adult Day Health Care Centers. Instead, the State requests technical assistance from CMS as it moves forward with the implementation of the changes required in SB 1755. California acknowledges that it is exploring a Section 1915(i) SPA, but that it does not have the funding or staff to implement such a SPA by July 1, 2009, given the State's current budget deficit.

The State also responded that, while it can add personal care services provided by ADHC centers to the State's personal care services benefit, doing so would be inappropriate. The State does not allow a Medi-Cal beneficiary to attend an ADHC center solely for the purpose of receiving personal care services. A copy of the State's comments is attached.

CMS RESPONSE

Although coverage for ADHC services is approved in the California State Plan, ADHC services are not recognized under section 1905(a) of the Act as a specific coverable service. Further, due to the habilitative nature of ADHC services, they do not meet the definition of rehabilitative services at 42 CFR 440.130¹. Therefore, the State must amend its State Plan to remove ADHC services as a covered service. Alternatively, the State also has the option to amend its State Plan to recognize ADHC centers as providers of section 1905(a) services authorized under the State Plan, such as, physical therapy, nursing, and personal care services, delivered in an ADHC setting.

We will work with California to remove coverage of ADHC services from the State Plan and address the issues identified in this report through our review of ongoing State Plan activities and through the eSPA initiative.

¹ Through the Omnibus Budget Reconciliation Act of 1989, certain states were grandfathered to provide day habilitation services to individuals with mental retardation or related conditions under the rehabilitation or clinic benefits of the state plan. The service had to be approved in the state plan on or prior to June 30, 1989.



State of California—Health and Human Services Agency
Department of Health Care Services



ARNOLD SCHWARZENEGGER
Governor

NOV 14 2008

Ms. Gloria Nagle
Associate Regional Administrator
Division of Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

Dear Ms. Nagle:

Please find attached the State of California, Department of Health Care Services' (DHCS or Department) response to the Centers for Medicare and Medicaid Services' (CMS) draft report entitled "Report on Financial Management Review of California Adult Day Health Care Program."

DHCS would like to thank CMS for the exit conference and written report provided regarding CMS' Financial Management Review of California's Adult Day Health Care (ADHC) Program.

DHCS would like to point out that CMS has recognized ADHC as an approved program for over 30 years. There has been an approved State Plan in place for California's ADHC program since the early 1980's. Prior to the State Plan, the ADHC Program was under an approved 1115 Demonstration waiver, which was implemented in 1977.

The Department does not agree with CMS' recommended timeframes for implementing changes to the State Plan. As CMS is aware, Senate Bill (SB) 1755 (Chapter 691, Statutes of 2006, Chesbro) signed by the Governor in September 2006 completely reforms the ADHC Program. If the State is given the time and support to completely implement this legislation, CMS' concerns regarding specific ADHC services and the reimbursement methodology will be resolved.

Ms. Gloria Nagle

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SB 1755 will make the following changes to the ADHC Program:

- Tighten the eligibility and medical necessity criteria for authorization of ADHC services. This will ensure that only those Medi-Cal beneficiaries that require ADHC services to remain in their own homes will be authorized for these services.
- Add new requirements for the governing of the relationship between the ADHC center and the beneficiary's personal health care provider. This will ensure that the provision of ADHC services are correctly guided by and overseen by the beneficiary's personal health care provider and not just the ADHC center.
- Add new conflict of interest provisions for ownership of ADHC centers. This will ensure that ownership of ADHC centers is not self-serving at the expense of the beneficiary and the financial outlay of the State and Federal governments.
- Add new minimum service requirements (core services). This will ensure a minimum level of effort and provide an objective means of measuring the actual services being provided to each beneficiary.
- Unbundle the current all-inclusive daily service code and reimbursement rate and implement a new prospective cost-based rate methodology. SB 1755 provides for a smaller bundled rate that will include the core services and the administrative expenses of the ADHC center. DHCS is aware that CMS does not want professional nursing bundled with the other core services and is willing to work with CMS to find an equitable manner in which professional nursing can be provided and reimbursed appropriately. The core service rate will be determined under a prospective cost-based methodology.

In addition to the smaller bundled code and rate, the ADHC centers will be required to bill separately for the separately billable services as specified in SB 1755. Rates for those services will be on a state-wide basis and will be based primarily on what the State pays other providers for the same or similar services.

And finally, to hold costs down and discourage provision of excessive and unnecessary services, each ADHC center will be under a daily reimbursement cap that will determine the maximum daily reimbursement rate for each center. This cap will probably also be determined by the prospective cost-based methodology.

Ms. Gloria Nagle

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Under SB 1755's payment methodology, the California Department of Aging will be conducting post-payment reviews of all ADHC centers and when discrepancies are found in service delivery or the medical necessity for received services, DHCS will be able to recoup the reimbursement for those services.

DHCS is attempting to reform the ADHC program in a manner that both resolves CMS' concerns and preserves the ADHC program so that Medi-Cal beneficiaries can continue to receive vital services that will maintain them in their homes and will avoid premature or unnecessary institutionalization.

DHCS has been working with CMS staff in looking at the (i)SPA and believes that this option warrants further exploration and discussion. However, at this time the State does not have the infrastructure in place to allow immediate implementation. In order to place the ADHC program under an (i)SPA, additional department funding and staff will be required. This is unlikely given the State's multibillion dollar deficit.

Should you have additional questions or wish to discuss the ADHC program further, please feel free to contact Mr. Irvin B. White, Jr., Chief of the Medi-Cal Benefits, Waiver Analysis and Rates Division, at (916) 552-9619.

Sincerely,



Stan Rosenstein
Chief Deputy Director
Health Care Programs

Enclosure

**Response to the Centers for Medicare & Medicaid Services'
Draft Report Entitled**

**"Report on Financial Management Review of California
Adult Day Health Care Program"**

RECOMMENDATION

1. The DHCS must submit a SPA that reflects a reimbursement methodology that is not dependent upon a bundled rate methodology and that excludes the reimbursement of non-1905(a) services.

CMS recommends that the DHCS review and evaluate if the above recommendation might be best achieved by seeking approval for a Section 1915(i) SPA, which allows the use of bundled rates. Alternatively, the State could submit a Section 1915(c) waiver, which also allows reimbursement of bundled rates. Both alternatives may allow the State to include in the payment rates additional costs beyond those allowed as 1905(a) services.

RESPONSE

The State is actively engaged in discussion regarding the 1915(i) SPA option. DHCS has had several conference calls with CMS staff and is also discussing this option with both internal and external stakeholders. The State does not view the 1915(c) waiver as a viable option.

As iterated previously however, the time and resources it will take for the (i)SPA will preclude an approved SPA by July 1, 2009.

RECOMMENDATION

2. The DHCS must submit a SPA that identifies ADHC centers as a specific site where personal care services may be delivered.

RESPONSE

The State can include ADHC centers as a place of service for personal care services in its SPA; however, the State considers it inappropriate to include the ADHC personal care services (as defined in SB 1755 and included as part of the ADHC centers' core services) as part of the State's Personal Care Services Program.

The personal care services provided at an ADHC center was and is not currently meant to be a part of the State Plan Personal Care Services Program because the ADHC personal care services are provided in the context of the participant's Individual Plan of Care and the specific ADHC services being received. The State would never authorize a Medi-Cal beneficiary to attend an ADHC center solely for the purpose of receiving personal care services.

RECOMMENDATION

NOTE: The State Agency must have an approved SPA that addresses and corrects the issues covered by the two recommendations above by July 1, 2009. Failure to do so will put Federal funding at risk.

RESPONSE

A SPA that can be approved by July 1, 2009 would require submission by September or October of this year. The State will not be prepared and have all the necessary processes determined and in place by that time. Again, the State asks for CMS patience as DHCS continues on the fast track for full implementation of SB 1755. DHCS asks for ongoing technical assistance from CMS staff and is prepared to remain engaged in productive discussions as the implementation of SB 1755 proceeds.